

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

## CERTIFICATE OF DEATH

02474

Reg. Dist. No. 66

## 1. PLACE OF DEATH:

County Crescent  
 City or town Ridgely  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 35 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Caroline  
 City or town Ridgely  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex F 5. Color or race W. 6. (a) Single, married, widowed, or divorced widow

6. (b) Name of husband or wife H. E. Beumington7. Birth date of deceased (mo., day, yr.) June 2nd 1864

8. AGE: Years 81 Months 8 Days 6 (c) If alive, give age years  
 (If less than one day) hrs. min.

9. Birthplace Powellville, Maryland  
(Town, county, and state)10. Usual occupation Telephone Operator

## 11. Industry or business

12. Name Hugh W. Laird13. Birthplace Maryland14. Maiden name Mary Boyd15. Birthplace Maryland16. Informant Walker BeumingtonAddress Ridgely, Md.17. Buried (Burial, cremation, or removal. Which?) Date thereof 37-10-46  
(month) (day) (year)Cemetery or crematory Ridgely CemeteryLocation Ridgely, Md.18. Funeral director J. Virgil Brown & SonAddress 16 Decatur19. March 9 1946 Registrar J. Davis

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1946 at 9:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 20 1946 to March 7 1946  
 and that I last saw him alive on March 6 1946

Immediate cause of death Cerebral Hemorrhage DURATION 1.5 days

Due to arterio sclerosis and hypertension 4 yrs +

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul Matthews M. D. or otherAddress Deaton Rd Date signed 3/9/46

RECEIVED  
MAR 11 1946  
BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92

## CERTIFICATE OF DEATH

Reg. Dist. No. 64

1. PLACE OF DEATH: Caroline  
 County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 26 years  
 Hospital, institution, or street address where death occurred:  
R.F.D.  
 How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war no

## 3. (a) FULL NAME

A. J. Brittain Sr.

## 3. (b) Social Security Number

no

4. Sex M. 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Susan A. Brittain  
 6.(c) If alive, give age 70 years  
 7. Birth date of deceased (mo., day, yr.) December 6, 1872  
 8. AGE: Years 73 Months 2 Days 29 If less than one day  
 .....hrs. ....min.

9. Birthplace See County, Va.  
 (Town, county, and state)  
 10. Usual occupation retired farmer  
 11. Industry or business " "  
 12. Name Charleswell Brittain  
 13. Birthplace Va.  
 14. Maiden name Mary E. Jones  
 15. Birthplace Va.

16. Informant Mrs. A. J. Brittain Sr.  
 Address Federalburg, Md.  
 17. Burial Date thereof 3-7-1946  
 (Burial, cremation, or removal Which?) (month) (day) (year)  
 Cemetery or crematory Stillcrest Cemetery  
 Location Federalburg, Md.  
 18. Funeral director Harry E. Williams  
 Address Federalburg, Md.  
 19. March 6 19 46  
 (Date rec'd by registrar) J. F. Garis Deputy Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 5, 19 46, at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Jan. 10, 19 46 to March 5, 19 46  
 and that I last saw him alive on March 5, 19 46

Immediate cause of death Chronic  
myocarditis

## DURATION

10 yrs.

Due to.....  
 Due to.....  
 Other conditions.....

(Include pregnancy within 3 months of death)

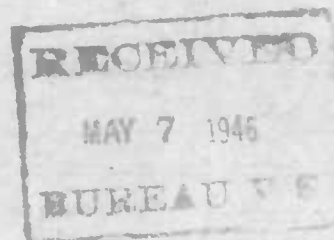
Major findings of operations.....  
 Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?.....  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE M. D.  
Bridgell, M.D. M. D. or other  
 Address..... Date signed 3/5/46



Evidence for addition of age & birth date of deceased is shown on

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of age & birth date of deceased is shown on

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15-2

02475

## CERTIFICATE OF DEATH

Reg. Dist. No. 66

FILM NO. I O 1 MAR 19 1946

### 1. PLACE OF DEATH:

County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....  
 Hospital, institution, or street address where death occurred:  
 .....

How long in hospital or institution?.....

### 3. (a) FULL NAME

Edward Brown.

### 3. (b) Social Security Number

4. Sex..... 5. Color of race..... 6. (a) Single, married, widowed, or divorced.....

7. Birth date of deceased (mo., day, yr.).....

8. (b) Name of husband or wife.....

8. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....

8. AGE: Years Months Days If less than one day  
 50 6 13 hrs. min.

9. Birthplace.....  
 (Town, county, and state)

10. Usual occupation.....

### 11. Industry or business

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Buried..... Date thereof.....

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Mar 5..... 1946

(Date rec'd by registrar) Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....  
 (If rural, give LOCATION)

2. (a) If veteran, name war.....

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... 19 46

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1 19 46 to March 1 19 46

and that I last saw him alive on March 1 19 46

Immediate cause of death.....

Pulmonary Tuberculosis

Due to.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

Address.....

Date signed.....

1946

RECEIVED

MAR 6 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(932)

02476

## CERTIFICATE OF DEATH

★ Reg. Dist. No. 64

## 1. PLACE OF DEATH:

County Caroline  
 City or town Federalsburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 19 years  
 Hospital, institution, or street address where death occurred:  
Greenidge Road  
 How long in hospital or institution? -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Caroline  
 City or town Federalsburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Greenidge Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war -

## 3. (a) FULL NAME

Margaret W. Cade

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife -  
 7. Birth date of deceased (mo., day, yr.) April 12, 1861  
 6. (c) If alive, give age - years  
 8. AGE: Years 84 Months 11 Days 3 If less than one day - hrs. - min.

9. Birthplace Sussex County, Delaware  
 (Town, county, and state)  
 10. Usual occupation Housework  
 11. Industry or business Home

FATHER 12. Name John Cade  
 13. Birthplace Sussex County, Delaware  
 MOTHER 14. Maiden name Elizabeth Barwick  
 15. Birthplace Sussex County, Delaware

16. Informant Mrs. Frank L. Williams  
 Address Federalsburg, Maryland

17. Burial Date thereof March 19, 1946  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Denton Cemetery  
 Location Denton, Maryland

18. Funeral director J. J. Frampton and Son  
 Address Federalsburg, Maryland

19. March 16 19 46 J. J. Frampton  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 19 46 at 1 A. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 12 19 46 to Mar 15 19 46  
 and that I last saw him alive on Mar 15 19 46

Immediate cause of death Coronary Thrombosis  
Hypertension &  
myocarditis  
 DURATION 2 weeks  
10 yrs.

Other conditions -  
 (Include pregnancy within 8 months of death)

Major findings of operations - Date of op. -

Autopsy results -  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide - Date of -  
 Where did injury occur? - (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -  
 Means of injury - Injured at work? -

23. SIGNATURE Frank M. Anderson M.D.  
Federalsburg Md. M. D. or other 3/16/46  
 Address - Date signed 3/16/46

RECEIVED  
MAR 19 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 737

## CERTIFICATE OF DEATH

Reg. Dist. No. 02477 60

## 1. PLACE OF DEATH:

County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....  
 Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Rebecca Catherine Camper

## 3. (b) Social Security Number

4. Sex.....

5. Color or race.....

6.(a) Single, married, widowed, or divorced.....

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....

8. AGE: Years..... Months..... Days..... hrs..... min.

9. Birthplace.....

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial..... Date thereof.....

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. (Date rec'd by registrar)..... Registrar.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... at..... A.. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... to..... and that I last saw her alive on.....

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....

(City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where)?.....

Means of injury..... Injured at work?.....

23. SIGNATURE.....

Address.....

Date signed.....

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

RECEIVED  
MAR 21 1946  
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77

## CERTIFICATE OF DEATH

02478

Reg. Dist. No. 62

## 1. PLACE OF DEATH:

County CarolineCity or town near Denton  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State \_\_\_\_\_ County \_\_\_\_\_

City or town \_\_\_\_\_  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mrs. Gertrude Foos

## 3. (b) Social Security Number

4. Sex

F

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

widow.

6. (b) Name of husband or wife

John Foos

7. Birth date of deceased (mo., day, yr.)

Sept 20<sup>th</sup> 1865

B. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

80511

If less than one day

hrs.

min.

9. Birthplace

Germany  
(Town, county, and state)

10. Usual occupation

at home

11. Industry or business

FATHER

12. Name

John Porter

13. Birthplace

England

MOTHER

14. Maiden name

Pauline

15. Birthplace

Germany

18. Informant

Mrs. Anna Stappert

Address

Denton Md

17.

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Buried  
Wells Creek Cemetery

Location

Near Denton

18. Funeral director

J. Virgil Mann & Son

Address

Denton Md

19.

(Date rec'd by registrar)

3/5

19.

467m 10George

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1946 at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 26 1933 to March 3 1946and that I last saw him alive on March 2 1946

Immediate cause of death

arterio sclerosis

DURATION

6 yr

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. Carl Throth M.D.

M. D. or other

Address Denton Md Date signed 3/4/46

RECEIVED  
MAR 14 1946  
BUREAU V. B.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(952)

## CERTIFICATE OF DEATH

0247962  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County Caroline  
City or town Hillsboro Rural  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 yrs.  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Caroline  
City or town Hillsboro Rural  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Herman H. Hill

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Sarah7. Birth date of deceased (mo., day, yr.) May 13, 1875 B. (c) If alive, give age 55 years8. AGE: Years 70 Months 18 Days 16 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Harrington Del.  
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Isaac Hill13. Birthplace Del.14. Maiden name Mary E. Rhyer15. Birthplace Del.16. Informant Mrs. Sarah E. HillAddress Hillsboro Md.17. Burial Date thereof 4/1/46  
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory HillsboroLocation Hillsboro, Md.18. Funeral director Raymond B. RawlingsAddress Greensboro Md.19. 3/30 19 46 Med. Officer  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH March 29 19 46 at 4:30 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2 19 42 to March 29 19 46  
and that I last saw him alive on March 16 19 46Immediate cause of death Coronary thrombosis DURATION shelteredDue to Generalized arterio-sclerosis years

Due to \_\_\_\_\_

Other conditions Emphysema of the lungs, Myocarditis years  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Am. Lederer M.D. M. D. or other \_\_\_\_\_Address Green Cross Md. Date signed 3/30 46

RECEIVED  
APR 2 1946  
BUREAU V.L.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

## CERTIFICATE OF DEATH

02480

Reg. Diat. No. 61

## 1. PLACE OF DEATH:

County Caroline  
 City or town Greensboro, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 35 yrs.  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Caroline  
 City or town Greensboro  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ✓

## 3. (a) FULL NAME

Anna Earickson Hopkins

## 3. (b) Social Security Number

4. Sex F 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife James P. Hopkins  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) June 23, 1860  
 8. AGE: Years 85 Months 9 Days 4 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Greensboro, Md.  
 (Town, county, and state)

10. Usual occupation House wife

11. Industry or business \_\_\_\_\_

12. Name Thomas J. Earickson

13. Birthplace Maryland

14. Maiden name Sarah Comegys

15. Birthplace Maryland

18. Informant Mrs. Alice Wieneke

Address Greensboro Md.

17. Burial Date thereof 3/30/46  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Greensboro

Location Greensboro, Md.

18. Funeral director Raymond B. Rawlings

Address Greensboro, Md.

Mar 29 1946 Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 27, 1946 at 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 27, 1946 to March 27, 1946

and that I last saw her alive on March 27, 1946

Immediate cause of death Bronchial Pneumonia

DURATION 2 day

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Chronic myocarditis

✓ Hypertension  
 (Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Antopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Clark H. Strough

M. D. Greensboro Md.

Address \_\_\_\_\_ Date signed 28 1946

RECEIVED  
APR 1 1946  
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1315

## CERTIFICATE OF DEATH

02481

Reg. Dist. No. 6D

## 1. PLACE OF DEATH:

County..... CarolineCity or town..... Denton  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?..... full lifeHospital, institution, or street address where death occurred:  
R. F. H. - Concord -How long in hospital or institution?..... no

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)Street No.....  
(If rural, give LOCATION)2.(a) If veteran, name war..... no

## 3. (a) FULL NAME

Alva Hubbard

## 3. (b) Social Security Number

none

## 4. Sex

m.

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife..... Hattie Hubbard7. Birth date of deceased (mo., day, yr.)..... February 16, 1870

## 8. AGE:

76 Years- Months21 Days

If less than one day

..... hrs. .... min.

8. Birthplace..... Federalburg, R. F. D.  
(Town, county and state)10. Usual occupation..... farmer11. Industry or business..... "12. Name..... W. M. J. Hubbard13. Birthplace..... md.14. Maiden name..... Lena A. Wright15. Birthplace..... md.16. Informant..... Mr. Alva HubbardAddress..... Denton, Md.17. Burial Date thereof..... 3-9-1946  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory..... Concord CemeteryLocation..... Concord, Md.18. Funeral director..... Harry WilliamsonAddress..... Federalburg, Md.19. 3/8 19 46 Thos B. George  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 3-7-1946 19..... at 3:45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 1 19 42 to Mar. 7 19 46and that I last saw him alive on Mar. 6 19 46

Immediate cause of death

Cardio Vascular Renal  
disease

DURATION

4 9/10

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE..... Thos B. George M. D. or otherAddress..... Denton Date signed..... 3/8/46

12420

STANLEY H. CRISTOFALDI, JR. & COMPANY

RECEIVED

RECEIVED  
MAR 14 1946  
BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 483

## CERTIFICATE OF DEATH

02482 60  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County Templeville  
 City or town Templeville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 months  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution? ✓

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Caroline  
 City or town Templeville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Lola Madeline Hurd

## 3. (b) Social Security Number

221-05-6637

4. Sex F. 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Amos Hurd  
 8.(c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Aug. 25 1909

8. AGE: Years 36 Months 6 Days 22 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Templeville, Caroline, Md.  
 (Town, county, and state)

10. Usual occupation House wife

11. Industry or business ✓

12. Name Sterny E. Lowman

13. Birthplace Maryland

14. Maiden name Molly E. Canelon

15. Birthplace Maryland

16. Informant Amos Hurd

Address Wyoming Del.

17. Burial Date thereof 3/19/46  
 (Burial, cremation or removal. Which?) (month) (day) (year)

Cemetery or crematory Templeville

Location Templeville, Md.

18. Funeral director Raymond B. Rawlins

Address Fredensboro, Md.

3/18 19 46 A.C. Smith

(Date read by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 19 46 at 1345A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 14 19 44 to March 16 19 46 and that I last saw her alive on March 13 19 46

Immediate cause of death Carcinoma of Cervix uteri  
with metastases  
to pelvic structures

DURATION  
approx  
2 yrs.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

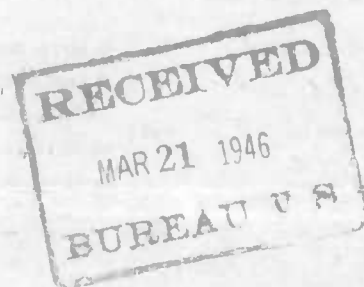
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Charles H. Stoughton M.D.

M. D. or other \_\_\_\_\_

Address Greenwood Date signed 3/18

1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1312

02483

## CERTIFICATE OF DEATH

Reg. Dist. No. 61

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

It less than one day

61

2

11

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

18. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Mar. 21

19. 46 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 16, 19. 46 to March 21, 19. 46

and that I last saw her alive on March 21, 19. 46

Immediate cause of death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. 9/2/46

Address

Date signed

1946

RECEIVED  
MAR 25 1946  
BUREAU VS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 472

## CERTIFICATE OF DEATH

02484

Reg. Dist. No.

60

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal (Whichever))

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1946 at 3:54 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

RECEIVED  
MAR 14 1945  
BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 61

## 1. PLACE OF DEATH:

County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex.....  
 5. Color or race.....  
 6.(a) Single, married, widowed, or divorced.....

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....  
 8. (c) If alive, give age..... years

8. AGE: Years..... Months..... Days.....  
 If less than one day..... hrs..... min.

9. Birthplace.....  
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. (Burial, cremation, or removal, Which?).....

Date thereof.....

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. (Date rec'd by registrar).....

Registrar.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... at.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....  
 and that I last saw him/her alive on.....

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Where did injury occur?.....

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?.....

23. SIGNATURE.....

Address.....

Date signed.....

1946

RECEIVED  
APR 4 1946  
BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 62

## 1. PLACE OF DEATH:

County CharlesCity or town New Denton  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Mrs. Margaret Porter7. Birth date of deceased (mo., day, yr.) Aug. 17<sup>th</sup> 18708. AGE: Years 75 Months 7 Days 20 If less than one day  
hrs. min.9. Birthplace New Denton Maryland  
(town, county, and state)10. Usual occupation Retired Farmer

11. Industry or business

12. Name Charles Porter13. Birthplace Maryland14. Maiden name Margaret Barrett15. Birthplace Maryland16. Informant Mrs. Margaret Porter (wife)Address Bd. 1 Denton, Md.17. Buried Date thereof 3-29-46  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Denton CemeteryLocation Denton Md18. Funeral director J. Virgil Moore & SonAddress 1 Denton, Md.19. 3/29 1946 Wm D D Jones  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County CharlesCity or town  
(If outside city or town limits, write RURAL and give nearest town)Street No.  
(If rural, give LOCATION)

2 (a) If veteran, name war

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1946, at 11 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Mar. 24 1946 to Mar 26 1946and that I last saw him alive on Mar. 26 1946

Immediate cause of death

Cowdery Thrombosis

Due to

ArteriosclerosisDue to Circled vs. Cular Disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles H. Stover, M.D.Address Greenlawn Md Date signed 3/27/46

RECEIVED

APR 1 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02487

Reg. Dist. No. 63

## 1. PLACE OF DEATH:

County..... Caroline  
 City or town..... Bethlehem  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 36 years  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Caroline  
 City or town..... Bethlehem  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... RFD  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war.....

## 3. (a) FULL NAME

W. Wesley Prettyman, Sr.

## 3. (b) Social Security Number

4. Sex..... Male 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Widower  
 B. (b) Name of husband or wife..... Emma A. Prettyman  
 7. Birth date of deceased (mo., day, yr.)..... Jan 19, 1866 6. (c) If alive, give age..... years  
 8. AGE: Years..... 80 Months..... 1 Days..... 12 If less than one day..... hrs. .... min.

9. Birthplace..... Laurel, Del.  
 (Town, county, and state)  
 10. Usual occupation..... Farmer  
 11. Industry or business.....

FATHER 12. Name..... John Wesley Prettyman  
 13. Birthplace..... Delaware  
 MOTHER 14. Maiden name..... Hannah Truitt  
 15. Birthplace..... Delaware

16. Informant..... Bernice P. Higgins  
 Address..... Preston, Md.

17. Burial Date thereof..... Mar 4, 1946  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory..... Spring Hill  
 Location..... Easton, Md.

18. Funeral director..... H. M. Hollis  
 Address..... Preston, Md.

19. 3/4 19 46 C. H. Plummer  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 29, 1946 at 3 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 19 33 to Mar. 19 46  
 and that I last saw him alive on Feb. 28th 19 46

Immediate cause of death..... Valvular heart disease 12 yrs.  
Arterio sclerosis 15 yrs.

Due to.....  
 Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury..... Injured at work?

23. SIGNATURE..... Shelton S. Seymour M. D. or other  
 Address..... Easton, Md. Date signed 3/4/46

RECEIVED  
MAR 5 1946  
BUREAU V E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

03109

Reg. Diat. No. 64

## 1. PLACE OF DEATH:

County Caroline  
 City or town Federalburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
Academy Avenue  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Caroline  
 City or town Federalburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Academy Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Lettie F. Stevens

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife Edward Stevens  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) March 22, 1868  
 8. AGE: Years 77 Months 11 Days 21 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Federalburg, Maryland  
 (Town, county, and state)  
 10. Usual occupation Housework  
 11. Industry or business Home  
 12. Name Joseph T. Frampton  
 13. Birthplace Talbot County, Maryland  
 14. Maiden name Caroline Dilakey  
 15. Birthplace Dorchester County, Maryland

16. Informant Mrs. Francis Neal  
 Address Federalburg, Maryland  
 17. Burial Date thereof March 15 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Free Crest Cemetery  
 Location Federalburg, Maryland  
 18. Funeral director J. J. Frampton and Son  
 Address Federalburg, Maryland  
 19. March 15 1946 S. J. Frampton  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 19 46 at 1:05 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 1 19 46 to Mar. 13 19 46  
 and that I last saw h. p. a. alive on Mar. 13 19 46

Immediate cause of death Chronic Myocarditis DURATION 3 yrs.  
 Due to arteriosclerosis & Hypertension 5 yrs.  
 Due to \_\_\_\_\_  
 Other conditions Malnutrition  
fracture of hip due to 1945  
 (Include pregnancy within 3 months of death) accidental fall, January 24, 1945  
 Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Frank M. Anderson M.D.  
Federalburg Md. M. D. or other \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed 3/15/46

RECEIVED

MAR 19 1946

BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02488

## CERTIFICATE OF DEATH

Reg. Dist. No. 62

## 1. PLACE OF DEATH:

County Caroline  
 City or town Denton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
Lincoln Street  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Caroline  
 City or town Denton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Lincoln Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.

## 3. (a) FULL NAME

Lillie A. Tucker

## 3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife Samuel L. Tucker  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) September 28, 1880  
 8. AGE: Years 65 Months 5 Days 14 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Denton, Caroline County, Maryland  
 (Town, county, and state)

10. Usual occupation Midwife

## 11. Industry or business

12. Name John L. Barnes

13. Birthplace Norfolk Virginia

14. Maiden name Sarah E. Pennington

15. Birthplace Talbot County Maryland

16. Informant Mrs. Dolly L. Eribbitt

Address Denton, Maryland

17. Burial Date thereof March 17, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Denton Colored Cemetery

Location Denton, Maryland

18. Funeral director J. J. Trautman and Son

Address Dyersburg, Maryland

19. 3/14 1946 Thos O George  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1946, at 12:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19\_\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_\_, and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_\_.

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Due to Cardiac Occlusion Sudden

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Thos O George George Car-  
 Address Denton M. D. or other \_\_\_\_\_  
 Date signed 3/14/46

RECEIVED

MAR 18 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

 02489 66  
 Reg. Dist. No.

## 1. PLACE OF DEATH

County Queen Anne's  
 City or town Ridgely Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 days  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County Queen Anne's  
 City or town Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION) ✓  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Agness Regina Wheeler

## 3. (b) Social Security Number

4. Sex

F

5. Color of race

C

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.)

Jan 12, 1946

8. AGE:

Years

Months

Days

If less than one day

25

hrs.

min.

9. Birthplace

Laurelino Caroline Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

Clarence Wheeler

13. Birthplace

Cyterville Queen Anne Md.

14. Maiden name

Virgie Carter

15. Birthplace

Hagerston Del.

16. Informant

Virgie Wheeler

Address

Queen Anne Md.

17.

(Burial, cremation, or removal (which?))

Date thereof

3/19/46  
(month) (day) (year)

Cemetery or crematory

Thomas Town

Location

Near Ridgely Md.

18. Funeral director

Raymond B. Rawlings

Address

Greensboro, Md.

19.

(Date rec'd by registrar)

March 18, 46J. D. Davis

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

March 17

19

46

at

2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 13

19

46

to

March 17

19

46

and that I last saw him alive on

March 16

19

46

Immediate cause of death

Pneumonia

DURATION

3 days

Due to

Due to

Other conditions

Under treatment onsame  
birth

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Charles T. Stanger

M. D.

Address

Greensboro Md.

Date signed

March 18, 46

RECEIVED  
MAR 20 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 02490

## 1. PLACE OF DEATH:

County..... Caroline  
 City or town..... Preston, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 30 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... Caroline  
 City or town..... Preston  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war.....

## 3. (a) FULL NAME

Addie J. Wright

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

H. B. Wright

## 7. Birth date of deceased (mo., day, yr.)

Sept. 23, 1890

## 6. (c) If alive, give age..... years

## 8. AGE:

Years

Months

Days

If less than one day

5564

hrs.

min.

## 9. Birthplace

Goldsboro, Caroline, Maryland

(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

## FATHER

## 12. Name

Robert Jarrell

## 13. Birthplace

Caroline

## MOTHER

## 14. Maiden name

Addie Noble

## 15. Birthplace

Caroline

## 16. Informant

H. B. Wright

## Address

Preston, Md.

## 17.

Burial

Date thereof

Mar. 31, 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

## Cemetery or crematory

M. E. Church Grave Yard

## Location

Preston, Md.

## 18. Funeral director

H. M. Hollis

## Address

Preston, Md.

## 19.

March 3019 46C. W. Plummer

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Mar 2719 46 at 11:15 P. M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 11 19 33 to Mar 27 19 46and that I last saw him/her alive on Mar 27 19 46

## Immediate cause of death

Cerebral Hemorrhage

## DURATION

104 hr

## Due to

## Due to

## Other conditions

Previous Cerebral Hemorrhage

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.....

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

## Means of injury

Injured at work?

## 23. SIGNATURE

W. E. Gannon M.D.

M. D. or other

Address: Federalsburg Md Date signed: Mar 29 46

APR 1 1946

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73-2

## CERTIFICATE OF DEATH

02491

Reg. Dist. No. 63

## 1. PLACE OF DEATH:

County.....

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

82.

2

15

hrs.

min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER

12. Name.....

13. Birthplace.....

MOTHER

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17.

(Burial, cremation, or removal, Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19.

March 2

19 46

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH..... March 2 19 46 at 11:00A M

2E. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1 19 46 to March 2 19 46

and that I last saw him or her alive on February 28 19 46

Immediate cause of death.....

Chronic Myocarditis

General arteriosclerosis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of Injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....

Date signed.....

RECEIVED  
MAR 5 1946  
BUREAU